Medication Management: Common Survey Findings (2026)

This resource summarizes common medication management findings identified during surveys related to assisted living regulations at Minnesota Statute 144G.71 and home care regulations at Minnesota Statute 144A.4792. The examples provided are intended to help providers identify areas of risk, strengthen internal audits, and improve compliance with Minnesota requirements. While not an exhaustive list of deficiencies, these findings reflect issues frequently reviewed by surveyors.

Providers should use this resource alongside the applicable Minnesota Department of Health (MDH) survey tools and compliance resources. These resources reflect many of the records, observations, and practices reviewed during surveys.

Assisted Living

- Resident Observation and Record Review Tool
- Additional MDH Assisted Living Survey Resources

Home Care

- Client Observation and Record Review Tool
- Additional Licensed Home Care Survey Forms and Resources

Survey findings and survey priorities may change over time. Providers should always refer to current statutes, rules, and MDH guidance.

Section 1: Policies and Procedures for Clinical Oversight and Supervision

Surveyors may review the organization's medication management policy manual to make sure it is current, comprehensive, and reflects appropriate clinical oversight. This includes reviewing policy revision dates and evaluating whether medication management practices are implemented, monitored, and supervised in accordance with applicable regulatory requirements.

Note: Oversight and supervision requirements vary by provider type. Assisted living providers should refer to Minnesota Statute 144G.71, and home care providers should refer to Minnesota Statute 144A.4792 for applicable requirements.

Common Survey Findings

- Medication orders were implemented before required verification was completed.

- Medication reconciliation was not completed or documented when required.
- Clinical oversight activities were incomplete, missing, or not documented.
- Delegation of medication-related tasks was not adequately documented.
- Required staff competency evaluations were missing, overdue, or incomplete.
- Medication administration record (MAR) inaccuracies were not identified or corrected through routine oversight.
- Medication records lacked individualized instructions.
- Staff could not explain medication administration procedures or required follow-up actions.

Section 2: Medication Assessment and Reassessment

Surveyors may review documentation to ensure individuals served receive timely and comprehensive medication-related assessments and reassessments, particularly following any change in condition. Emphasis is placed on clear, complete documentation that supports ongoing evaluation of medication needs.

Common Survey Findings

- Required medication assessments or reassessments were missing or incomplete.
- No reassessment was completed following a change in condition or medication-related concern.
- Assessments did not fully address medication-related needs, risks, or services.
- Assessment documentation did not support the medication management services provided.

Section 3: Individualized Medication Management Plan

Surveyors may check service plans, MARs, recent medication change orders, and hospital discharge records to confirm each individual served has an individualized and up-to-date medication management plan. Documentation should reflect resident or client-specific instructions and timely updates following any medication changes.

Common Survey Findings

- Individualized medication management plans were missing or incomplete.
- Plans lacked clear, individualized medication instructions.
- Plans were not updated after medication changes or changes in need.
- Medication reconciliation was not completed or documented when required.
- Medication management records did not accurately reflect current services or orders.

Section 4: Prescriptions and Orders

Surveyors may review prescriber orders, prescriptions, and MARs to ensure accuracy, completeness, and consistency. They will look for evidence that orders are current, correctly transcribed, and implemented without delay.

Common Survey Findings

- Current medication orders or prescriptions were missing or unavailable.
- Medication orders had expired and were not renewed as required.
- MAR entries did not match current prescriber orders.
- Medication orders were transcribed incorrectly.
- New or changed orders were not implemented in a timely manner.

Section 5: Medication Administration

Surveyors may review medication administration practices and MAR documentation to ensure medications are given safely and accurately. This includes verifying correct dose, timing, technique, and proper documentation of administration, refusals, and follow-up.

Common Survey Findings

- Medications were not administered according to prescriber orders.
- Required medication administration documentation was missing or incomplete.
- Staff signatures, initials, or credentials were missing from medication records.
- Medication refusals, omissions, or missed doses were not documented.
- Required follow-up actions were not documented when medications were not administered.
- *Pro re nata* (PRN) (as needed) medication administration or effectiveness monitoring was incomplete.

Section 6: Medication Setup

Surveyors may check medication management records, such as MARs, and the organization's medication setup policy to ensure medications are prepared safely, accurately, and in accordance with established procedures.

Common Survey Findings

- Medications were set up incorrectly or inconsistent with current orders.
- Incorrect doses or administration times were prepared.
- Medication setup documentation was missing or incomplete.

Section 7: Self-Administration of Medications

Surveyors may review assessments and monitoring practices related to self-administration to ensure individuals served are appropriately evaluated and supervised. Documentation should demonstrate ongoing evaluation of the individual's ability to safely self-administer medications.

Common Survey Findings

- Individuals were self-administering medications without a supporting assessment.
- Ongoing monitoring of self-administration was not documented.
- Changes in condition did not trigger reassessment of self-administration abilities.

- Medication storage arrangements did not support safe self-administration.

Section 8: Medication Storage and Security [Assisted Living Only]

Surveyors may review medication storage areas and related documentation, such as temperature logs, to ensure medications are stored securely and under proper conditions. This review may include medication carts, medication rooms, resident apartments or units, and other resident-specific medication storage locations. Surveyors will assess compliance with requirements for labeling, expiration monitoring, storage conditions, and secure access for prescription and over-the-counter medications, as well as topical medications, eye drops, oral rinses, and other medication products.

Common Survey Findings

- Medications were accessible to unauthorized individuals.
- Medication storage areas were unlocked or inadequately secured.
- Temperature logs were missing, incomplete, or not reviewed.
- Out-of-range temperatures were not addressed or documented.
- Medication labels were missing, incomplete, or illegible.
- Expired or discontinued medications remained in active storage.
- Medications were not stored in accordance with provider policy or manufacturer instructions.
- Controlled substances were not adequately secured or accounted for.